	ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL For use of this form, see AR 608-75; the proponent agency is OACSIM.							
			PRIVACY ACT ST	TATEMENT				
Programs; DoDD Child Developme PRINCIPAL PURPOSE: Information will Army's Exceptio			3, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and D 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, nent Services; and E.O. 9397 (SSN). I be used to assist Army activities in their responsibilities in overall execution of the fonal Family Member Program (EFMP) and the Army Child and Youth Services Program.					
	DISCLOSURE:	Disclosure of red	•	• .		not provided individual may		
	Part A - General Information							
1.	Child's Name					2. Date of birth (YYYYMMDD)		
3.	Family member prefix							
4	Type of placement request	ed:				5. Date (YYYYMMDD)		
	Type of placement request					o. Bate (TTTTWWBB)		
6.	Sponsor name					7. SSN (last four digits)		
8.	Spouse name				·			
9.	Home phone		10. Duty phone		11. Cell	phone		
		Part B -	 Identification of Child	 Youth Condition/Res	trictions			
Child has any of the following conditions/restrictions: (Check yes or no)								
1.	Allergies No		Yes (explain)					
	a. Life threatening reaction No	n	Yes (explain)					
	b. Epi-pen required No		Yes					
	c. Other allergic reations (hives, rash, diarrh	rea) Yes					
2.	Asthma reactive airway dis	sease	Yes (explain)					
	a. Triggers exist for child's	s asthma attacks	(stress, environmental, ex Yes (explain)	rercise)				
	b. Child routinely (greater No	than 10 days per	month/four months per y Yes (explain)	ear) uses inhaled anti-in	nflammator	y agents and/or bronchodilators		
	c. Child has taken steroids	s during the past	year (prednisone, prednisone) Yes (indicate number of					

	d. Child has e	No No	sness or seizures associated with asthma attacks Yes (explain)
	e. Child requir	red an urgent visit to em No	nergency room or clinic for acute asthma within the last 12 months Yes (indicate number of visits in the past year)
	f. Child has b	een hospitalized for asth	nma related condition in the past six months Yes (explain)
3.	Attention Defi	cit Disorder (ADD) No	Yes
	a. ADD with I	hyperactivity No	Yes
	b. Is not well	controlled with medicati	ion Yes (not well controlled)
	c. Behavioral/	conduct concerns	Yes (explain)
4.	Autism	No	Yes
5.	Behavioral/con	nduct concerns (for exam	nple, oppositional defiant disorder, anxiety disorder, school phobias) Yes (explain)
6.	Blindness/visu	al problems No	Yes (explain)
7.	Diabetes	No	Yes (explain)
8.	Emotional prob	blems that require care b	y a psychiatrist, psychologist or social worker Yes (explain)
9.	Epilepsy	No	Yes (explain)
10	. Hearing prob	lems No	Yes (explain)
11.	. Heart probler	ms No	Yes (explain)
12.	. Kidney proble	ems No	Yes (explain)
13.	. Speech/langu	uage delay No	Yes (explain)
14.	. Physical disa	bility No	Yes (explain)
15.	. Dietary restri	ictions No	Yes (explain)

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16. Assistance with activities of da	ily living Yes (explain)				
17. Other conditions No	Yes (specify and explain)				
	Part C - Medications				
Child is on medications on a regular					
No	Yes (If yes, please list medications and indicate which require administration during child care hours.)				
	Part D - Early Intervention and Special Education				
	ervice Plan (IFSP), Individualized Education Plan (IEP) or 504 plan				
No	Yes				
	Part E - Exceptional Family Member Program (EFMP) Enrollment				
Child is enrolled in the EFMP No	Yes (specify for what condition)				
I authorize medical information regarding m	(name of Medical Treatment Facility or physician's practice) to release any y child (name of child) to the				
	(name of installation) Child Youth Services (CYS)/Special Needs Accommodation				
Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the CYS/SNAP in reliance on this authorization prior to revocation is valid and will remain in effect.					
I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025.18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.					
-	ch includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the t in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this				
Signature of Pa	arent or Personal Representative of Child Date (YYYYMMDD)				

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